



INSTRUCTIONS AND INFORMATION FOR  
COMPLETING THE EVIDENCE OF  
INSURABILITY FORM  
Unum Life Insurance Company of America

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries. The insurance product is underwritten by Unum Life Insurance Company of America.

To expedite processing, this form has been designed to be scanned and optically read. Please print neatly and respond to all questions.

1. Fully complete this form when your plan requires you to be individually underwritten to qualify for insurance. Specify what coverage you are requesting. If you are unsure, check with your plan administrator.
2. Make sure you have answered all the questions completely and accurately. Information pertaining to your Employer name, address and Group number, as well as your personal information must be provided. If there are unanswered questions, the underwriting process will not begin.
3. All employees and spouses applying for any coverage requiring underwriting must answer all health questions through section 2. If you are applying for disability coverage, or your life amount requiring underwriting is greater than \$150,000, you must also fill out section 3.
4. Please include your work and home phone number; we may need to request additional information by telephone.
5. Please sign and date where indicated and make a copy of this form for your records. Please send the completed form to your plan administrator or mail the form directly to:

Unum  
P.O. Box 9783  
Portland, ME 04104-5083

In order to evaluate your application we are relying on the information you have provided. In addition, we may need to request supplemental information from you or your physicians. Some coverage and amounts may require a brief medical exam, a blood test, urinalysis and/or EKG. These tests will be performed at your convenience and can be completed at your place of employment or home. We will notify you if any additional information is needed. Unum will pay for any additional information or tests needed to evaluate your application.

**CAUTION:** If your answers on the application are incorrect or untrue, Unum may deny benefits or rescind your insurance. Any person who, knowingly and with intent to defraud or deceive any insurance company, submits an insurance application containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.



EVIDENCE OF INSURABILITY  
Unum Life Insurance Company of America

Application Type:  Initial Request  Late Applicant  Annual Enrollment  
 Change in Status  Increase  Portability

List Your Current Height

-   
Ft. In.

Weight

Lbs.

List Your Spouse's Current Height

-   
Ft. In.

Weight

Lbs.

Employee Social Security Number

-  -

Gender

Male  Female

Group #

Group #

Division #

Employee First Name

M.I. Last Name

Date of Birth - mm/dd/yyyy



Details for any "yes" answers

Question Number	Name	Detailed Description	Date	Duration	Treatment Received and Recovery	Names and Addresses of Physicians and Hospitals

Please attach additional sheet if you need additional space

Authorization

I authorize any person or organization to give Unum subsidiaries or their duly authorized representatives (Unum) any of the following:

- information about any injury or illness I have or I have had, including Acquired Immune Deficiency Syndrome (AIDS), mental illness or drug or alcohol abuse. This authorization excludes disclosure of Human Immunodeficiency Virus (HIV) test results. Such test results shall not be disclosed or published. I understand that nothing in this caveat will prohibit this authorization from including the fact that an applicant has Acquired Immune Deficiency Syndrome (AIDS).
- information about my medical history including any consultations, prescriptions, treatments or benefits.
- copies of all records that may be requested concerning me or my family members, and
- non-medical information about me or my family members.

The term person or organization, which is used above, means a physician or medical practitioner, a hospital, clinic or other medical treatment facility, any insurance or reinsurance company, insurance support or reporting agency, pharmacy, government agency, or employer.

I understand that the information obtained by use of this authorization will be used by Unum to determine eligibility for insurance and eligibility for benefits. Unum will not release any of the obtained information to any other person or organization except reinsuring companies or other persons or organizations performing services in connection with my application or claim.

I understand that this authorization shall be valid for two years from the date shown on the application and that a photographic copy of this authorization shall be as valid as the original. I understand that I have the right to revoke this authorization at any time except to the extent it has been relied on prior to written notice of revocation. I also understand that, if I revoke this authorization, such revocation may be a basis for denying insurance benefits. This authorization may be revoked by sending written notice to: Unum, Attn: Group Medical Underwriting, P.O. Box 9783, Portland ME 04104-5083.

The statements I have made on this application are true to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the group policy for which Evidence of Insurability is required. I have read and understand the Authorization, and I and my authorized representative have a right to receive a copy. I understand that failure to sign this Authorization may impair Unum's ability to process my application or evaluate a claim, and that this may be a basis for denying my application or claim for benefits.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Child Signature (if 18 or older)

\_\_\_\_\_  
Date



8QXP XQGHUVWDQGV \RXU SulyDF\ LV LPSRUWDQW :H YDOXH R  
WR SURWHFWLQJ WKH FRQÀGHQWLDOLW\ FIKQRQSWELFLH S[SOVRL  
FROOHFW 13, ZKDW ZH GR ZLWK 13, DQG KRZ ZH SURWHFW \RX

:H FROOHFW 13, DERXW RXU FXVWRPHUV WR SURYLGH WKHP ZL  
LQFOXGH WHOHskRQH QXPEHU DGGUHVV GDWH RI ELUWK RFF  
FHLYH 13, IURP \RXU DSSOLFDWLRQV DQG IRUPV PHGLFDO SUR  
VXSSRUW RUJDQL]DWLRQV DQG VHUYLFH SURYLGHUV

:H VKDUH WKH W\SHV RI 13, GHVFULEHG DERYH SULPDULO\ ZLW  
DQG SURIHVVLRQDO VHUYLFHV IRU XV VXFK DV KHDSLOKDXVHS D  
13, ZLWK PHGLFDO SURYLGHUV IRU LQVXUHQFH DQG WHB, DWPKH  
DQFH VXSSRUW RUJDQL]DWLRQ 7KH RUJDQL]DWLRQ PD\ UHWDL  
LW SHUIRUPV VHUYLFHV ,Q FHUWDLQ FDVHV ZH PD\ VKDUH 13,  
DXGLWLQJ SXUSRVHV :H PD\ VKDUH 13, ZLWK SDUWLHV WR D S  
RU IRU VWXG\ SXUSRVHV :H PD\ DOVR VKDUH 13, ZKHQ RWKHUZ  
VKDULQJ ZLWK JRYHUQPHQWDO RU RWKHU OHJHO DVXWRXWL S\HLU

:H KDYH SK\VLFD O HOHFWRQLF DQG SURFHGXUDO VDIHJXDUG  
13, :H JLYH DFFHV V RQO\ WR HPSOR\HHV ZKR QHHG WR NQRZ W  
VHUFLFHV WR \RX

<RX PD\ UHTXHVV DFFHV V WR FHUWDLQ 13, ZH FROOHFW WR SU  
YLFHV <RX PXVW PDNH \RXU UHTXHVV LQ ZULWLQJ DQG VHQG I  
FOXGH \RXU IXOO QDPH DGGUHV V WHOHSCRQH QXPEHU, DQG XS  
UHTXHVV ZH ZLOO VHQG FRSLHV RI WKH 13, WR \RX ,I WKH 13  
WKH KHDOWK LQIRUPDWLRQ WR \RX WKURXJK HDZLHOODWV RDVHHQS  
LQIRUPDWLRQ UHODWHG WR GLVFORVXUHV :H PD\ FKDUJH D UH

7KLV VHFWRQ DSSOLHV WR 13, ZH FROOHFW WR SURYLGH \RX  
OHFW LQ DQWLFLSDWLRQ RI D FODLP RU FLYLO RU FULPLQDO S

,I \RX EHOLHYH 13, ZH KDYH DERXW \RX ERXLO DRUWWHFW V & BHO  
IXOO QDPH DGGUHV V WHOHSCRQH QXPEHU DQG S<ROXLF O G XPEH  
VKRXOG DOVR H[SODLQ ZK\ \RX EHOLHYH WKH 13, LV LQDFFXUD  
13, DQG QRWLI\ \RX RI WKH FRUUHFWLRQ :H ZLOO DOVR QRWLI  
UHFV 13, IURP XV LQ WKH SDVW WZR \HUV LI \RX DVN XV WR F

,I ZH GLVDJUHH ZLWK \RX ZH ZLOO WHOO \RX ZH ZLHO Q B WY HR LR  
UHDVRQ V IRU RXU UHIXVDO :H ZLOO DOVR WHOQ<R R W W D W H F  
VKRXOG LQFOXGH WKH 13, \RX EHOLHYH LV FRUUHFW ,W VKRXO  
ZLWK RXU GHFLVLRQ QRW WR FRUUHFW WKH 13, LQ RXU AOHV  
:H ZLOO LQFOXGH \RXU VWDWHPHQW DQ\ WLPH ZH GLVFORVH W  
WR DQ\ SHUVRQ GHVLJQDWHG E\ \RX LI ZH PD\ KDYH GLVFORVH  
WZR \HUV

,I ZH GHFLGH QRW WR LVVXH FRYHUDJH WR \RX ZH ZLOO SURY  
VLRQ :H ZLOO DOVR WHOO \RX KRZ WR DFFHV V DQG FRUUHFW I

)RU DGGLWLRQDO LQIRUPDWLRQ DERXW 8QXP Z\Z F8QXPPL WR PH SW LV  
RZZ FRORQLDRODZIUH WHPWR 3ULYDF\ 2IAFHU 8QXP &RQJU  
ODLQH :H UHVHUYH WKH ULJKW ZLHO P SCURIY LKHL VRQ RZL WFKH D  
PDNH PDWHULDO FKDQJHV WR RXU SULYDF\ SUDFWLFHV



< 8QXP \$OO ULJKWV UHVHUYHG 8QXP LV D UHJLVWHUHG WUDGHPDUN DO  
VXEVLGLDULHV 7KH LQVXUDQFH SURGXFW LV XQGHUZULWWHQ E\ 8QXP /LIH